Pinaymootang First Nation Health

Annual Report on Health 2022- 2023

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ACCREDITED WITH EXEMPLARY STANDING


PINAYMOOTANG
FIRST NATION


THOMPSON
ELECTRIC
ANDERSON

TABLE OF CONTENTS

INTRODUCTION

As leader of the community, it is an honor and privilege to once again present to you the annual report on Health for fiscal period 2022-23. I am privileged to be involved in an organization that plays such an active role in the lives of our community members. The health and well-being of each one of us is a gift, a treasure that we have been blessed with and something that we must always protect.

In this report you will find a year filled with continued service delivery, information on the accomplishments and activities of the past year as we work towards common goals for the benefit and well-being of health. Teamwork, dedication and perseverance have always been the key, which have resulted in accomplishments achieved. Our community health programming intent will continue to:

- Provide open communication efficiently and effectively;
- Be guided by principles of fairness and equity;
- Encourage and support participation in activities;
- Actively grow in unity; and
- Be transparent and accountable to the general public to whom we serve.

The mission and vision of Pinaymootang Health Centre is to advance health knowledge, build capacity by promoting awareness, self-care, develop tools and processes in health education.

I thank the Health Centre staff for their hard-working efforts in making our health programs a success. Without their care and dedication, it would be impossible to sustain and improve health in our community.

In closing, I thank you for this opportunity as we are here to ensure that the future in health is prosperous and filled with hope and determination.

Respectfully yours,

Chief Kurvis Anderson & Council

MESSAGE FROM THE HEALTH ADVISORY COMMITTEE

This report was prepared under the guidance and approval of the Health Advisory Committee, in accordance with the reporting criteria as outlined in the Health Transfer Agreement.

All material and fiscal implications have been considered in preparing the Annual Report on Health.

On behalf of the Pinaymootang First Nation Health Advisory Committee we hope that you find this information useful.

Sincerely,

Health Advisory Committee

Director of Health Annual Report

Well another fiscal year has come to an end and we once again provide you to this year's annual report on health for fiscal period ending March 31, 2023. Each year in health brings many new challenges and our hands-on approach allows us to quickly direct resources to where they are most needed.

Pinaymootang Health works to ensure that patient rights for safe and adequate health care needs are met. We strive to prevent and reduce risks to individual health and community health.

As we move along to this year's report, I am so happy to report that in this fiscal year we had gone through another Accreditation review and we are happy to report that Pinaymootang Health have received Accredited with Exemplary Standing.

I wish to personally thank health staff for being such great champions in health programming and going through this journey together, but without you and your hard work and dedication you made it all possible.

Governance Structure

The Pinaymootang First Nation Health Advisory Committee responsibilities are to oversee and provide recommendations in health. The Health Advisory Committee meets on a regular monthly basis every last Thursday of each month to review reports, policies, staffing issues and other related concerns. This past fiscal year have altered many of our meetings due to spacing issues. The role of the committee is to represent Chief and Council to whom it is accountable, in that role the committee is responsible for providing recommendations on health and management.

Health Program Overview

Nursing Treatment & Prevention – the Nursing component in health continues to be challenging in our facility. Pinaymootang have seen 47% increase in services that is way beyond our scope of services. The Health Centre is a very extremely active facility and at times difficult to keep up with its work load. The public health program component continued its best to ensure our client needs are met, providing immunizations; flu clinics, encouraging physical activity and awareness, facilitating community education awareness sessions, and attending to all emergency health needs. The community currently employs 2 Registered Nurses, and 4 LPN's who work and have helped out in different capacities in health.

The First Nation does have two visiting physician services with Dr. Chumber of the IERHA and Dr. Theissen whom provides services in pre-natal and well women's clinic. It has been noted that a total of 411 clients have been seen during this reporting period.

Community Health Representative – The CHRs continue to play a major role in health programming both employees oversee additional programs within their scope of work. One CHR focuses on children, youth and school setting while taking on the CPNP program and the other CHR focuses on adult and elderly care as well as the ADI program. Both CHR's are committed in ensuring excellent program service delivery in their respective roles.

Support to Nurses – One Administrative Assistant is on hand to help oversee the day-to-day front desk operations of the organization, duties include but not limited to the following; support services to nurses, physician's and visiting professionals; provide support to program managers, booking all specialty visits, organizing meetings, and all general required duties. During this reporting period, we required additional supports to meet our demanding service needs.

Operation and Maintenance of Health Facilities – The role of the operations and maintenance is to ensure the upkeep of health facility and with the expanded facility the scope of work has increased significantly. Maintenance continues to be contracted out on a need be basis. We have also hired the services of an infection control within our facility to continue to maintain a safe environment for both the client and staff.

National Native Alcohol and Drug Abuse Prevention – the goal of the NNADAP is to support our membership and the community to establish and operate programs aimed at stopping high levels of alcohol, drug and solvent abuse. Most of the NNADAP activities focus on the four areas of emphasis: prevention, treatment, training, research and development. The NNADAP program continues to support community designed and operated projects in alcohol prevention, treatment and rehabilitation in order to arrest and reverse the present destructive physical, mental, social and economic trends. The coordinator continues to provide the needed support and works closely with the visiting professionals in the area of mental health. Pinaymootang Health does have 3 visiting mental health professionals that provide supports to our community five days a week. We have seen increases in Mental Health during this reporting cycle.

Brighter Futures Initiative/Building Healthy Communities (Mental Health; Home Care Nursing; Solvent Abuse) – the Health Program currently employs one person to oversee the roles in the BFI and BHC program. The purpose of the BFI is to improve the quality of and access to culturally sensitive wellness services in the community. These services help create healthy family and community environments which support child development. The components and objectives of the BFI are mental health, child development, injury prevention, healthy babies and parenting skills. A variety of projects have been held throughout the year aimed specifically to mental health.

The role of the BHC program is to address gaps in the range of mental health services and activities related to crisis intervention and post-vention on-reserve.

Environmental Health Drinking Water Safety Program – The Health Program currently employs an individual on a half time level. The Drinking Water Program continues to meet its components as outlined in the agreements, such as sampling, testing drinking water, recording results on water quality, providing monthly reports to First Nations and Inuit Health Branch - Health Canada, for interpretation and recommendations in determining E. Coli and total coliforms, inspecting and reporting on general sanitation, providing public awareness, develop contents for school, supports action on health status inequalities affecting members according to identified priorities and ensuring all pertinent procedures are followed, maintained and updated.

Canada Prenatal Nutrition Program (CPNP) - this program is designed to improve the health of pregnant women and their babies. The objective is to improve the adequacy of diet of prenatal, to promote breast

feeding, to increase the access to nutritional information, to increase the number of infants fed aged appropriate foods in the first twelve months of life.

In Home and Community Care Program – the HCC Program currently employs; 1 HCC Nurse Supervisor, 3 Health Care Aides. The program currently meets its mandate with 125 plus clients. This program has been very active in providing basic care supports on a daily basis, assessments, medical equipment, etc.

NIHB Medical Transportation – is administered by one Medical Transportation Coordinator, one part-time Assistant Coordinator and 3.5 medical drivers. The purpose of the Medical Transportation Program is to provide transportation benefits to eligible First Nation members to the nearest access to medically required services that cannot be obtained in community. The program continues to intake medical appointments, verifying, scheduling in coordination of transportation based on the guidelines of FNIHB. The program runs a 4-van medical transportation system. The medical vehicles are now equipped with safety mechanisms to ensure safety, this fiscal period was a very challenging time.

Aboriginal Diabetes Initiative – the ADI Program is designed to improve the health status of First Nations individuals, families and communities through actions aimed at reducing prevalence and incidence of diabetes and its risk factors. Diabetes is the biggest health challenge currently facing First Nations and this is one area we focus on, is the preventative measures that diabetes can be prevented. Diabetic awareness activities continue to take place, foot care services is provided on a bi-weekly schedule.

HIV/AIDS – The HIV/AIDS Program has continued to meet its components of the program, workshops, information sessions, awareness to promote safer activities, available counseling and supporting testing.

Aboriginal Head Start On-Reserve (AHSOR) – the AHSOR Home Visitor Coordinator is available in providing screening of families very early after the birth of a child from 0 to 6 years of age to identify risk factors and assist families with supports such as expanding and enhancing programs and support services for mothers, pregnant moms, caregivers, parents, parents to be, children and their families. The AHSOR Program is active in community and is a participant in the Dolly Parton Imagination Library. The Health Centre have worked to develop on-line forms in child development and have conducted virtual activities to ensure the continuum of programming.

Accreditation - The Pinaymootang First Nation (PFN) Health Centre made a commitment to continue on with the accreditation process with Accreditation Canada, to ensure that the highest standard of services is provided in a safe health care environment. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations across Canada and around the world. The Pinaymootang First Nation Health Centre have gone through a renewal process on September 2022. We are proud to announce that we have attained the highest level in the accreditation process and were awarded with "Accredited with Exemplary Standing".

Jordan's Principle, Child First Initiative Program – Niniijaanis Nide (My Child My Heart Program) – The program continues to grow. We have been faced with many challenges such as appropriate office spacing in which we do not have. The role of Jordan's Principle is to ensure that our most vulnerable health needs are met, to help assist with child development and basic care needs around the circle of care model for both the child and the family.

eHealth – Pinaymootang offers the following eCMR (electronic charting system) with Mustimuhw, Telehealth Services, eChart (electronic health record), and Panorama which is a comprehensive, integrated public health information system designed for public health professionals that helps professionals view and man-

age more effectively on vaccine inventories, immunizations, investigations, outbreaks and family health. One of our goals is to one day have one eCMR that would improve health care communications to both our internal and external health partners that will improve the pathway of care for clients.

Maternal Child Health (MCH) – Strengthening Families, Maternal Child Health Program is new program that was recently expanded in the region. Pinaymootang was fortunate to be one f the communities selected. The purpose of this is to enhance 0-6 child health services. We are a home visitation program offered to pre-natal moms and families with children from birth to 6 years old.

Other Initiatives:

Network Meetings – the Health Centre still involves itself in community networking with our internal community stakeholders to facilitate partnership building. Many meetings have been halted due to the pandemic.

Interlake-Eastern Regional Health Authority (IERHA) - the Health Program continues to be great partners in dealing with issues and concerns to ensure improved health care of services for our region. If you have not heard yet, Ashern hospital will be expanding and will offer many great changes in the upcoming year. Pinaymootang Health is also part of MyHealthTeam in partnership with IERHA. MyHealthTeam is an approach to care that brings health care providers closer to home. MyHealthTeams are made up of a variety of professionals who will complement work that is currently being provided. Our hopes are these services become well utilized. We offer such services in Mental Health and Chronic Disease. We hope to get virtual physiotherapy services going by September 2023.

Southern Chiefs Organization – Like many First Nations in the southern Manitoba, Pinaymootang took an interest in health transformation development which is intended to create a new southern health governance structure that is representative of, and accountable to, its communities. The model is a community-led project that brings holistic, physical, spiritual, mental, economic, environmental, social, and cultural wellness by way of policies, creating of wellness plans, identifying evaluation, research and data systems, allocating resources, training and establishing service standards.

University of Manitoba – Pinaymootang has been partnering up with the University for a number of years. This year, we were able to do a lot of work through the Dementia Program in community to provide education, awareness and training. We hope to see the Heart and Stroke Foundation work starting in the new fiscal. The University of Manitoba has become huge partners in enhancing health services that bring support and action to many areas of health.

Caring for Adults with Exceptionalities – This one-year pilot project that will commence in April 2023 is intended for young people with complex needs and disabilities who face numerous challenges and barriers as they start transitioning through life. This proposal will provide an opportunity to empower and educate people with disabilities as they face stages of life transitions with personal and professional skills in a supportive environment, which leads to increased self-esteem, confidence and self-reliance. We will build on self-awareness, advocacy and self-knowledge on disabilities and help overcome barriers by promoting an understanding of the impacts of their disability

In closing, I would like to express to the community in all your efforts in following protocols and trusting your Health Centre. We hope you find this report useful.

Yours respectfully,
Gwen Traverse

Community Health Nurse Annual Report

In the past few months, I have heard so many people express that they have no idea where the last 3 years have gone; and that time during the pandemic sped by faster than ever before. So much of "normal life" was more complicated or just plain put on hold. Fear and frustration became a daily emotional state. Mandated isolation periods caused distance between family and friends, while the threat of personal loss shifted into an ever-hovering reality for many.

Throughout the pandemic, mental health crises increased exponentially. Depression, anxiety, addiction, chronic stress has all become more prevalent. The signs of mental and physical stress are evident not just on the faces of the health care staff at hospitals and at the Health Centre, but also on all of the clients that come through the doors. There is a sense of exhaustion that time and distance from the intensity of the pandemic has not yet soothed.

So how do we heal? How do we move forward into each new day? How do we renew some of the energy and optimism that brand-new days used to bring? There is a huge push in society to take care of ourselves first and others later. There is definitely some wisdom in taking care of ourselves so that we are fueled up to meet the challenges of life, but we also cannot ignore the healing power of taking care of those around you; of participating in community.

Please consider the following suggestions for refueling and refreshing the mind, body and spirit as we meet each new, post-pandemic day.

Most importantly: remember to be kind to yourself even if you don't meet the expectations you set out for yourself. Be willing to change those expectations to a level you can achieve in the moment and raise the standard when you feel able.

- Drink water. Our bodies feel tired when we do not drink enough water. Improved hydration can also improve your energy and sense of well-being.
- Eat something. Leaving our bodies in starvation mode by skipping meals can add stress and lower mood. Try to choose whole foods more often than processed, if possible. Whole foods are foods that are as close to their unprocessed form as possible such as fruit, vegetables, nuts, meat, cheese, milk, yoghurt. Try to choose options with lower sugar and salt. I would also like to encourage intentional and mindful eating: when possible, sit down to eat, especially if there are friends or family members available to sit and eat with you. TASTE the food! Eat favorite foods or try new foods. Take a moment so that your body remem-

bers that it was fed and the food was good!

- Take a break. Sometimes our minds and bodies need to move and stretch and consider something different in order to return to our tasks with even better energy and focus.
- Sleep!! Our bodies probably need more sleep than we allow them. Recommended daily sleep times for a person's best ability to function and maintain good health change according to age. Infants need 12 to 17 hours; Toddlers to preschoolers need 10-14 hours; school aged children need 9-11 hours; teenagers need 8-10 hours; adults need 7-9 hours. Healthy sleep habits are also important to ensure a quality night sleep.
- Find a grounding exercise or activity that improves your mood. This can be something creative like art and journaling or active like walking or social like spending time with friends or quiet like deep breathing.
- Participate in family and community gatherings and events, if you are able. Volunteer or join in the planning and the activities. Seek out ways to help those in need in your community. Help your neighbors.
- Talk to someone. Every one of us has been affected by the pandemic. Every person can benefit from working through the after effects of the pandemic with a trained therapist. Pinaymootang is incredibly fortunate to have 2 caring therapists available.

The post pandemic world does not need to remain a solitary, isolated place. It will take time and effort for healing to take place and for normalcy to return. It has been an honor to work alongside the members of the Pinaymootang community and witness strength and resiliency shine through some very difficult years. I look forward to seeing how the community will grow and flourish in this next year.

Immunization Coordinator Statistics:

Child health visits 195
Adult Health visits 404
Phone calls 825

Total immunizations 825

Roxie Rawluk

Community Health Nurse Annual Report

After being on maternity leave for the year of 2021, I returned to working part time at the Health Centre at the beginning of January this year. Having been in the midst of the Covid-19 pandemic last year, many services were temporarily stopped or rearranged.

One of those being most interrupted was childhood immunizations. In the two days a week that I am at work, my main role is catching up on missed immunizations, which includes infant, preschool and school immunizations. Routine school immunizations take place in grade 6, but with the school closures, some students in later grades will need to be caught up. If your child is eligible or missing any immunizations, our CHR, Carol will be reaching out to you to inform you and ask for consent to have your child immunized at school. The 3 vaccines that are needed are Hepatitis B (HB), Human Papilloma Virus (HPV), and Menningococal (Men-quad).

If you have any further questions regarding any of the vaccines, please reach out to myself or any of the other nurses and we will be happy to provide you with more information as well as a factsheet regarding each one.

I am also continuing with postpartum and newborn assessments. Since Covid, we have been having mom bring her new baby to the Health Centre for this assessment, but we hope to soon return to in-home visits for the convenience of the family. What's really exciting is that it no longer just stops there. With the new Maternal Child Health program, which is being headed up by our nurse Kerri, more home visits will take place after the initial nurse home visit, to provide continued support during the transition phase. This, of course, is if the new mother would like these visits and could benefit from them.

I continue to assist with walk-ins and triaging for the doctor. Walk-ins are again starting to increase with people being more out and about and willing to go to different places. It's great to see our Health Centre being so well utilized by the community as this is who we are here to serve. We also answer many different questions and concerns over the phone.

As I was away for the majority of this last fiscal year; my stats for the time I have been here are as follows:

Immunization Entry: 113
Medication Administration: 11
Child Health Assessment: 11
Newborn Assessment: 10
Blood work: 61
Lab Result/Requisition Entry: 29
Pre-op Assessment: 3
Other Interactions: 165

Obstetric Entries: 38
Adult Health Assessment: 4
Baby Rourke Assessment: 41
Maternal Postnatal Assessment: 12
Follow-up: 9
Women's Health: 2
Wound Care: 6

Total Encounters: 521

HIV/AIDS Annual Report

The purpose of the HIV/AIDS program is to develop initiatives to control and prevent the spread of HIV infection on-reserve, to reduce the health, social and economic impacts of HIV/AIDS, to encourage and support the active involvement of community, to identify option and strategies for the provision of treatment, care and support programs that will facilitate knowledge that will provide timely and comprehensive education and preventative programs, to increase knowledge and educate to ensure that skills exist at the community level to develop a coordinated approach.

The HIV/AIDS program continues to grow and threaten the lives of our First Nation people as no one is immune from HIV/AIDS. The Pinaymootang First Nation Health program has come to realize that this disease with the infection rate is amongst communities where poverty, family violence and drug/alcohol abuse are present. The indicator of unprotected sexual activity, a very high sexually transmitted disease rate and a high teen pregnancy rate prove that we are at risk of HIV infection.

During the course of the year, we have been promoting that HIV/AIDS as well as Hepatitis C are preventable diseases. We have been educating that in order to prevent transmission we must practice safe precautions.

The following activities were conducted;

- Information drives
- Health Sex Education Classes;
- Promotion of World AIDS Day;
- Providing contraceptives, condom talk demos;

Community Health Nurse/Maternal Child Health Annual Report

Maternal Child Health

Greetings Everyone! Over the past year the Health Centre has seen the Strengthening Families Maternal Child Health Program come to life. The program was introduced to community members in June of 2022 with training for staff commencing in March. To date we have enrolled 49 families to the program. Enrollment to Maternal Child Health involves: intake, screenings, assessments and often further referrals. Families then receive services based on their needs, level of engagement and desire to participate in available community programs and home visits.

The primary goal of Maternal Child Health is to improve holistic health outcomes for our maternal, infant, and child population with attention paid to the family unit. Our areas of focus include prenatal health, postnatal health, newborn care, and the overall wellbeing of young children. This is achieved through education and programing in the areas of nutrition, early literacy / learning, physical, emotional and mental health as well a nurturing the bond between infant and caregiver. In addition to this we have cultivated the opportunity to improve the knowledge of reproductive health among teens and young adults by hosting a teen clinic at the school and various workshops. Along with the sharing of our curriculum, we have hosted independently or in partnership with other Health Center Programs, a number of community activities. Teen Clinic, babysitting classes, prenatal workshops, Elders gatherings, health walks, and play groups are some of the ways we have been able to connect with families.

The role of MCH Nurse Supervisor became part of the work that I do as a member of the Health Care Team. Much training went into the development of the Maternal Child Health program for all of our staff. This included; training through Growing Great Kids Curriculum, Integrated Strategies, Sacred Babies. Indigenous Doula, and Traditional Parenting. As part of my continuing education, I enrolled in and completed a Doula training program that has supported my work specifically with the prenatal population. This year has been a huge undertaking but such a wonderful opportunity to learn and grow in my career as a nurse but to also get to know more community members and the future generations. The care of our parental population has been integrated in to the work we are doing with Maternal Child Health. This was a natural move due to our program components and training. We are lucky enough to be blessed with a physician Dr. Phoebe Thiessen who will visit the community once monthly to support our prenatal needs.

Enrollment to Maternal Child Health: 49 Families
Events: 40 Group Activities with Families

Additional Nursing Duties:
In addition to the very important work with creating the Maternal Child Health Program, my portfolio at the Health Center continued to include the following; Prenatal Care, Maternal Postnatal visits, Harm Reduction,

STBBI Education / Management, Teen Clinic Services, along with Clinic assessments and treatments.

Highlights:
Harm Reduction - Harm reduction, refers to a scope of intentional practices and health related policies aimed to lessen the negative social and/or physical consequences associated with various human behaviors. Harm reduction initiatives are used to decrease the negative consequences or health outcomes of drug use and or unhealthy sexual activity without confrontation or judgement. It is a holistic approach to care that does not discriminate based on life style. It recognizes that people who are unable or unwilling to stop behaviors that may be deemed unsafe can still make positive choices to protect themselves, others and have successful outcomes in life.

Harm Reduction and Harm Reduction strategies look different to each person, it can also look different in each community dependent on what other services are available. As the Harm Reduction Coordinator at the Health Center my goal is to develop programming and build relationships with those in need, based on trust and respect. As Community Nurses we work hard to ensure the care provided by all health care staff is done so in a nonconfrontational and confidential manner. We welcome the opportunity to support you or a loved one to address needs in this regard and have education programs available to other community program providers. Sexually Transmitted Blood Bourne Infections

This portfolio and related work, continues to be of great importance and of high need. Incidences of Sexually Transmitted and Blood Borne Infections continues to be on the rise in Manitoba and in First Nation Communities. Nursing staff continues to make outreach and take supportive action to support community members in need and at greater risk. It is through our efforts at Teen Clinic and additional workshops at the school that we hope to educate as a means of prevention. Managing cases related to Sexually Transmitted and Blood Borne Infections (STBBI) requires proper diagnosing, effective and timely treatment, education and ongoing monitoring. This is to not only treat the person affected but to ensure that the risk of transmission is decreased to partners and to unborn children of infected mothers. Community members are welcome to present to clinic and will receive all services and supports available to them to manage any diagnosis that they face. This care is confidential and we can address matter quickly and effectively through open and honest communication.

Community Health Nurse Roles - The Clinic requires a great deal of attention as people with various needs present. Clinic duties include but are not limited to the following; adult and childhood assessments, bloodwork, referrals to other providers, wound care, mental health interventions and treatments. Support for the Home and Community Care program and attending to emergent needs are two additional ways I allocated my time and services.

Highlights:
Wound Care Visits: 118
Communicable Disease Visits: 195
Additional Nursing Care Visits: 517
Prenatal Care Women Health: 149
Infant Child Health Assessments: 102

Thank you to all the community members who I have had the opportunity to work with. It is my pleasure to be a part of the Pinaymootang Health Care Team. Wishing each of you happiness and good health.

Kind Regards,

Kerri Nickel
Community Health Nurse/ Nurse Supervisor Maternal Child Health

Community Health Nurse Annual Report

Hello, my name is Maegan Anderson. I have been employed as a Community Health Nurse for the Pinaymootang First Nation Health Program for the past 3 years.

I currently work 4 days a week at the Pinaymootang Health Centre and also hold employment at Lakeshore General Hospital in Ashern as an Acute care nurse. It has been such a pleasure to be able to provide safe and compassionate care that our people need and deserve.

In addition to working as a community health nurse I also work alongside the home and community care program; the IERHA chronic disease nurse and dietician; and also work with the Heart and Stroke foundation and the University of Manitoba on a new pilot project.

Working as a Community Health Nurse I am able to interact and help the people of my community and surrounding communities, ensuring they are receiving the upmost respect and dignity, and focusing on efficient patient-centered care. Providing services such as dressing changes, bloodwork, assessments, and medication administration.

The Home and Community care program allows me the opportunity to work with our elders. Providing home visits for things such as wound care (dressing changes), medication administration, blood work, wellness checks, assessments and more.

Working alongside the IERHA Chronic disease nurse and Dietician, I am able to send referrals for those who require assistance with the management of their chronic conditions such as diabetes, hypertension (high blood pressure).

The Chronic disease program aims to provide and maintain a high standard of management for patients with chronic diseases, which includes monitoring and development of individual plans that can help slow down the progression of the disease and/or help control the symptoms.

The Heart and Stroke Foundation and University of Manitoba are currently working on a pilot project aimed at providing community members the opportunity to talk about their experiences after a stroke or significant cardiac event, the experience of returning home and the care process.

The goal is to hear directly from the people in the community so they can adjust or reframe the national best practice guidelines to reflect their needs, which would allow the opportunity for specialized equipment and services to be brought into the community.

In closing, I would like to express how grateful and proud to be apart of the Pinaymootang Health Centre, working with such a great group of people and continuing to have the opportunity to work for my home community.

Statistics:

# of Home care visits: 313 # of General Clinic visits: 692 # of referrals to CDN/Dietician: 59

Maegan Anderson LPN - Community Health Nurse

Foot Care Nurse Annual Report

Hello Pinaymootang, my name is Brenda Henry, I am a Licensed Practical Nurse and have been employed at the Heath Centre as the Foot Care nurse since June 2019. In addition to my role here, I am also a community nurse in Winnipeg. My 18 years of nursing experience has focused on diabetic health and education, lower limb wound care, and preventative health education.

The services I provide at the Health Centre, and in community are:

- Nail care
- Basic foot and lower limb assessment
- Corn and callus reduction
- Client education on foot health and prevention measures to maintain healthy feet.
- Referrals to Community Nursing, Medical Specialists, and footwear fittings.
- Wound care

Our foot care program benefits all community members. Care is provided at the clinic, in community for people who have mobility issues, in hospital during extended stays and at long term care facilities. If you or one of your family members require foot care, please contact the Health Centre to arrange an appointment.

Each year the foot care program grows, and I am fortunate to meet more of our community members. Over the last four years I have been invited into elders' homes to provide foot care, but while I am there, I get to hear stories from their past, current update on their families, and share some of my own family's stories.

I attended the Canadian Association of Foot Care Nurses conference in May. This was the first in person conference since 2019. The conference was held in Winnipeg, and Dr. Embil and Dr Dascal, were keynote speak-

ers. We refer many of our community members to these two physicians, and they are an integral part of our health care team. The knowledge I gained from this conference will assist me as I care for our community members.

I continue to enjoy being a part of the Pinaymootang Health Centre team and look forward to the coming year.

Stats:

- Home Visits 62
- Hospital 9
- Long Term Care 10
- Clinic Visits 157
- Total Visits 238

Brenda Henry, LPN

Community Health Representative Annual Report

The Pinaymootang First Nation Health employs two Community Health Representatives who play a major role in the health program. Both CHRs currently oversee additional programs in their job duties, one focuses on school health, baby clinics and youth of the community. This position is responsible for the delivery of high standard community health surveillance programs and to provide quality health prevention and treatment in community.

Updates of immunizations are done through Panorama and eChart for all children that need immunizations. Immunizations are updated and entered in their personal EMR charts. Panorama, eChart and Mustimuhw are used to get medical information for new families that have moved service area or are from a different band affiliation. Panorama and eChart are also used to search for newborn medical numbers.

MIMS updates are requested for Hep B's, Adacel, Gardasil, Meningococcal, influenza and regular immunizations for babes when they are, 2 months, 4 months, 6 months, 12 months, 18 months, 5 years and Grade 6. Immunizations are an ongoing task. Mustimuhw & Panorama which we constantly use to make sure that the child/ren do not receive repeat immunizations. Immunizations are then entered.

A total of 104 flu vaccines were given to band members and non- band members in October, November, December and January, February. Charted and recorded in consent forms, personal charts (Mustimuhw), Panorama and in the Seasonal Influenza and Pneumococcal Immunization Data Entry form.

We have held 40+ clinics held during this fiscal:

- 18+ completed 1st and 2nd dose – 1059
- 18+ completed 3rd dose – 400
- 18+ completed 4th dose – 29
- 18+ 1st dose only – 26
- 5-11 1st and 2nd dose – 130
- 5-11 1st dose only – 30
- 12-17 1st and 2nd dose – 140
- 12-17 3rd dose – 26
- 12-17 1st dose only - 5

Preschool list is made and a copy is faxed over to the school for the teacher. A preschool clinic is set up for the kids to get a Denver Development Test and immunization is given to preschoolers before school starts and this is done by Nurse as CHR makes all appointment arrangements.
Head checks were not done this year due to Covid restrictions.

Triage is done in clinic before patients see the community physician, by CHR, Health Care Aides, mostly by LPN such as blood pressures, blood sugars, weights and are then recorded on personal chart.

Transportation is always provided for clients wanting to come in for Doctor's clinics, Dental, NNADAP, Nurses, Child Health Clinic's, Diabetic clinics, Blood Pressures, Workshops or as needed.

Meetings/Workshops/Conferences:

- Virtual Staff Meeting
- Staff Development Workshop
- Health Plan workshop
- Accreditation Updates
- Food handler's Course
- First AID & CPR
- Recreation Committee Meetings
- Handwashing Training
- Patient Safety Culture Survey
- Work Life Balance Survey
- Treaty Days
- Health Fair
- Health Centre Community Presentation
- Networking- Quarterly Meets
- Breast Screening

Canada Prenatal Nutrition Program Annual Report

The Canada Prenatal Nutrition Program (CPNP) is designed to improve the health of prenatal and postnatal women and their babies. We strive for well-nourished pregnant women, more women breastfeeding, and for as long as possible, greater access to nutrition information, services, increased knowledge and skill-building opportunities and the best infant feeding practices to ensure health babies.

Three main program areas in the program are Nutrition Screening, Education and Counselling, Maternal Nourishment (providing pregnant women and breastfeeding moms with health foods), Breastfeeding Promotion, Education and Support.

Pregnancy tests are done by nurse at the request of clients and if found that they are pregnant they are put on a prenatal list card for follow up. All bloodwork is done by the nurse and Healthy Baby Prenatal Benefit Application is given and mail out to Health Baby Manitoba, which in return they receive a supplement of $90.00. Prenatals are followed up by the community Doctor monthly.

Prenatal are seen according to the weeks they are pregnant:

12 Weeks - Pre & Post Natal Testing Blood work
18 Weeks - Maternal Serum Screening & Ultrasound
20 Weeks - Referral to Obs. (Fax Letter & Blood work)
28 Weeks - 50 gm Glucose Test
38 Weeks - Leave to Winnipeg to deliver

Nurse and the CPNP worker do home visits for newborns and moms as soon as returning to the community and Welcome Home Packages are given. Assessments are done to babe/mom, to see if there are any concerns that need to be addressed. Welcome Home Packages given (receiving blankets, wipes, nose bulbs, socks, bibs, mittens, t-shirts, nail clippers set, shampoo, body wash, baby lotion, sleepers, thermometers) and information packages were also made up and fridge magnets with immunization schedule. New Year's Baby - Boy or Girl receives a $95.00 Welcome Home Package plus a Baby Star Blanket along with information.

Ultrasounds are booked at Eriksdale Hospital and at times second ones are needed. They are then provided with travel from Medical Transportation Coordinator.

Prenatals are advised to be in Winnipeg for delivery as Ashern does not provide this service. In the case of need to deliver will be looked after in Ashern Hospital. Most prenatal are found in their first trimester, odd one will be found in last trimester.

Information packages on importance of immunization, healthy eating calendars and food guides, safety in

car/home, dental care, SIDS, breast/formula, baby manual for dads, pamphlets or booklets are given to post-natal's.

We have had 3 miscarriages this annual reporting year.
Prenatals are given a milk coupon, in which they get a 4-litre jug of 2% milk from the community store, once a week. Manual Breast pumps are given to mom at her request as she will be breastfeeding, usually a couple of months for some and some past 9 months.

Successes:

- Among the 36 prenatal mothers who consented to the program 35 have participated; there is 31 prenatal that are still in the program.
- Some continue to smoke and drink we have offered a preventive incentive for smoking cessation;
- None of the prenatal mothers do prohibited drugs;
- Booklet developed on Growing Healthy Together Baby and Me which facilitates bonding between mother and baby even during prenatal stages;
- The increase in care for pre and post natal;
- Mommy and Me Support Gathering;
- Milk program;
- Group activities;
- Cooking class for moms and dads

2022 April – March 2023 – 17 Boys & 16 Girls

New Year's Baby- Girl born January 5, 2023

Total babies born (33)

Meetings/Workshops/Conferences:

- Staff Meeting
- Staff Development workshop
- Chronic Disease Education & Training session
- Standard First Aid & CPR C
- Hand Wash Training
- Patient Safety Culture Survey
- CPNP Conference
- Work Life Balance Survey
- Accreditation Education
- ASSIST Training
- PHIA TRAINING

Community Health Representative 2 Annual Report

The Pinaymootang First Nation Health Program currently employs two Community Health Representatives (CHR's) were one CHR oversees adult and community health care while the other takes on the responsibility of school health, children and youth.

And as part of the health care team, my role as your community health representative is responsible in liaising between patients, families and health care providers to ensure patients and families understand their conditions and are receiving appropriate care. I have been working as a CHR for many years now and I really enjoy what I do.

The scope of the CHR Program directly impacts individuals and the community as a whole and by working with health care providers and the community to provide education, information and support on the health and well-being to individuals, families and communities based on a holistic approach to health and health care. The CHR supports services that encourage prevention, intervention and provide up to date information and resources to promote healthy living lifestyles through education, immunization, and clinics.

As a CHR, I also perform a broad range of duties in the community. Some of my duties throughout the fiscal year have included but not limited to the following:

- Acting as liaison and coordinator for the community, residents and professional staff;
- Providing information about childcare, nutrition, sanitation, communicable disease and other health matters;
- Conducting home visits to teach and demonstrate family health care and referring medical health problems to health professionals;
- Assisting with immunization consent forms;
- Translation;
- Participating in health information drives;
- Assisting in Health Education;
- Assisting with community health events (cleanup, health fair, workshops, etc.);
- Participated in the Accreditation Process;
- Monthly reporting and attending staff meetings;
- Nutritional and Physical Activity

And over the course of the fiscal year we have seen an increase in all of our services. Other than the CHR role I also take on the ADI Programming.

Aboriginal Diabetes Initiative Report

The role of the ADI is to provide an integrated, coordinated diabetes program in the area of diabetes prevention, health promotion, lifestyle support, care and treatment. As the ADI Coordinator my role is to reach the short-term and long-term goals which include;

- Raising awareness of diabetes;
- Risk factor assessments;
- The value of healthy lifestyle practices;
- Supporting the development of a culturally appropriate approach to care and treatment;
- Diabetes prevention;
- Health promotion; and
- Building capacity and linkages in the components of the program.
- Gardening Project

As many are aware, there are three types of diabetes; Type 1 is where the body makes little or no insulin; Type 2 is where the body makes insulin but cannot use it properly; and Gestational diabetes is where the body is not able to properly use insulin. Diabetes is a lifelong condition but one that can easily be managed and maintained by eating healthy and getting physically active.

We offer to our clients to:

Learn How to Prevent Diabetes: Learn when and how to screen for diabetes, importance of a healthy diet including reading nutrition labels and carbohydrate counting, as well as making healthy lifestyle choices.

Learn what diabetes is: How to test and control your blood sugar, treatments for diabetes, what to eat with diabetes, and how to read food labels. We will also talk about staying healthy from your eyes to your toes by making healthy lifestyle choices, modifying recipes, managing stress, physical activity, and understanding your blood sugar results!

Diabetes Class: Learn how to stay healthy from your eyes to your toes by making healthy lifestyle choices, modifying recipes, stress management, physical activity, and understanding your blood sugar results!

Eating for Heart Health: Love your heart! Learn about dietary changes to help you improve your blood pressure and cholesterol, medications to protect your heart, activity and stress management, and monitoring your blood pressure at home.

The Health Program has been very active in implementing the ADI Program to the community as well as my role in CHR. I look forward to another year filled with new programming.

Support to Nurses Annual Report

The role of support to nurses at the Pinaymootang Health Centre is Reception and Administration Support.

The main objective to ensure physical and mental health by assisting the professional staff of the Pinaymootang Health Centre, leading to the overall well-being of the members of our community.

The front desk reception organizes and maintains the functions of front desk duties. Also assists in various health departments of our organization when needed. The front desk ensures that every client's needs are being met, by directing them to the appropriate professionals such as doctor, pharmacist, nurse, or any one of our organizations program coordinators.

Pinaymootang is an accredited health facility and is a very fast paced environment with many different programming that ensures and promotes good health.

As the Administrative Support and Front Desk Receptionist my duties have included:

- Booking all appointments for Doctors, Foot care, Mental Health Therapists, and Telehealth
- Greeting & directing all incoming visitors
- Assisting the Doctor and Nursing staff with patient charting
- Storing pharmaceutical deliveries & distribution of prescription medications
- Correspondence with doctor/patient referrals
- Distributing & logging incoming and outgoing faxes/mail
- Help coordinate and organize specialty programming as instructed
- Preparing forms, documents, spread sheets
- Commitment to confidentiality

Throughout the past fiscal year, the number of patients that were seen: 411

Operations and Maintenance Report

The general duties conducted are general cleaning and sanitary services on a daily basis. Both interior and exterior cleaning of premises such as; carpets, furniture, windows, washrooms and floorings.

Removing of litter and garbage to the local landfill is done on a daily basis. The custodian ensures a high confidentiality level. Accurate cleaning is conducted throughout.

Other maintenance that is required such as lawn maintenance, HRV cleaning, lighting fixture change, snow removal, drainage, door fixtures, grading of parking lot are conducted through a need be basis by contract work.

The upkeep to the health facility has been a quite demanding and challenging throughout this fiscal year since the expansion of the Health Centre. During, physician days it is the most-busiest. The health facility as more than doubled its size which means a drastic workload for both custodian and maintenance. With this global pandemic, the Health Centre have gone through great lengths to ensure safety measures are met and many steps forward to ensure infection control.

This position can become quite challenging and enduring since the pandemic we have taken many steps to improve the quality of cleaning.

The Operations and Maintenance personnel has made every effort to ensure the upkeep in good of its health facility in good working order.

Maintenance & Operations

Brighter Futures Initiative/Building Healthy Communities Annual Report

The Brighter Futures Initiative Program is a community-based health promotion and ill-health prevention program. The program promotes health and prevents ill-health through learning-related activities that strive to increase awareness, change attitudes, build knowledge and enhance skills.

The Program Components

- Mental Health - The goal of this component is to promote the development of healthy communities through community-based mental health programs, services and/or activities. Information and awareness activities on a variety of topics such as family violence, stress management, counseling services and wellness activities.

- Child Development - Aims to ensure that children receive the nurturing they need to reach their full potential.

- Parenting - The aim of this component is to promote culturally-sensitive parenting skills.

- Injury Prevention - The goal of this component is to prevent injuries. Examples of activities funded include first-aid and CPR training, water safety workshops, awareness campaigns and promotion.

The Building Healthy Communities program is designed to develop community-based approaches to youth solvent abuse and mental health crisis. The two main components of the program.

- Solvent Abuse - Enables communities to develop local programs aimed at preventing the abuse of solvents and to intervene as needed, which could involve residential treatment.

- Mental Health Crisis Management - Is designed to complement the mental health promotion and prevention activities of the Brighter Futures Initiative Program. It enables communities to respond to crisis, such as suicide, as well as to heal from them. It also enables communities to receive crisis-related training, such as suicide prevention training.

To increase awareness in these different areas the BFI/BHC program, in partnership with various community agencies and other Health Centre programs, provides a variety of different activities for community members to participate in. These are some of the events/programming held in the past year: Beautification of Spring Clean Up, Participating in Network Meetings, PFN Annual Health Fair, the Life Saving Society to hold various safety courses and workshops, Swimming lessons and a Water Smart for Kids workshop, family day snowmobile ride, many training opportunities in Emergency Planning, and prepping for the Accreditation Review.

Native and Alcohol Drug Abuse Program Annual Report

My name is Alvin Thompson and I was born and raised in Pinaymootang. This year marks the 17th year since, I moved back to my home community in 2006 and started working in the NADAP program. As I reflect on our journey in these past few years since Covid was first mentioned in 2019, I feel my memory is somehow faint in terms of how things have evolved.

When Covid started it was something that was happening on the other side of the world and we never realized how quickly it would spread and affect the whole world. In our community we went through many things that we had never experienced before. Suffice to say that Covid changed many things. We experienced deaths in our communities, but we could not operate in the normalcy of how we did things before. Attendance to wakes and funerals were affected. Our work places, our place of worship, schools, stores, health services were all affected. These changes brought on other effects, such as; numbing our emotions, depression, fear, anxiety, dissociation, Isolation, alienation, anxiety and fear. In a way these factors can be viewed as suppressed emotions which in turn results in unresolved issues. When this occurs, then people have the tendency to turn to other ways to deal with the effects.

However, there are ways that these issues can be resolved. It is part of human nature for our bodies to react to its own coping mechanisms and these can vary from one extreme to the other both in positive or negative ways. It is for this reason that Pinaymootang Health Centre has worked diligently to have Mental Health Therapists available in our community. Any of our team can make a referral to the Therapists.

As an Addictions Counsellor, I work closely with the Therapists both to refer or design After Care plans for clients that have gone through Treatment Programs. It can be difficult to navigate through the established boundaries in the path of healing from unresolved grief issues or recuperating from the effects of the pandemic that affected us in so many ways. Anytime we encounter perils, determination and persistence results in healing. There is always Hope when we feel there is no where to turn. Our Health Care Team will always work with you and never against you. After care activities can include counselling, sharing circles, support groups, crisis intervention, support and outreach visits. More recently, the NADAP program has received

Land Based funding and the program has partnered with other collaterals to organize events for clients to attend and wellness and healing being the focal point.

The NADAP program has also been involved in organizing some professional development programs for staff. One such event took place June 2022 in Winnipeg and the topic was "Debriefing from Covid". However, for many of us we still deal with the after effects of the pandemic.

Another event took place within the community was in September 2022 on "Suicide Prevention & Awareness". The purpose of this event was for all staff to be trained in dealing with clientele that may show signs of ideation. In addition, it was to meet with Accreditation requirements.

On August 18, 2022 the Pinaymootang Health Centre held its annual Health Fair during treaty days. As always this has been a success for every year that we've had it in our community. Many other organizations attend the Fair to bring awareness and prevention in all facets of health care.

In the Fall of 2022, is when I was informed that the Land Based funding would become available. In preparation the yearly plans had to be modified and activities were listed that could be offered in the community. There was a feeling of excitement when this became a reality for many reasons. The obvious being that this is what was needed to address the high volumes of alcohol or drug problems that have arisen in our communities. In retrospect, I personally remember members of the community coming together when there was harvest of wild game such as moose or deer. As a child it was exciting to see our community coming together as animals were skinned, cut up, prepared. Large fires were made and cooking of the wild game occurred over open pit fires. Men and women coming together to cook and make bannock in various methods. The laughter and storytelling that was happening was so fulfilling and brings back many fond memories of my childhood. There was no drinking at these gatherings, no arguments, only sharing, laughter and feasting together. For many this has been the "missing link" in our lives.

At the time of writing this report, we continue to plan events and hopefully many successes will occur and that true healing will become our way of life. We have the Western methods, but foremost we need our Aboriginal identity to move forward. We need to rejuvenate what we lost. We need to learn to live off the land, we need to learn our way, the "original ways" of living and only then can we know where our journeys will go. I am pleased to present this report and happy that I can contribute to my home community for what I was gifted with.

The following is statistical information that is required from our funding sources:

Month	Number of clients	Events	Referrals	Other Communities
April	19		9	4
May	11		3	8
June	18	Debriefing 33	4	3
July	20		12	9
August	24	Health Fair 356	7	11
September	30	Training 20	15	8
October	33		9	12
November	15		5	1
December	5		1	1
January	11		2	1
February	23		6	4
March	25		9	7
Totals	**234**	**409**	**79**	**91**

Yours sincerely,

Alvin Thompson CAC II BSW RSW

Medical Transportation Annual Report

Hello, my name is Margaret Anderson and I am the Medical Transportation Coordinator for the Pinaymootang First Nation Health Program.

The Medical Transportation Program provides transportation benefits to eligible clients with access to required services that cannot be obtained within the community. This program is administered by one Medical Transportation Coordinator, one Medical Transportation Assistant and four Medical Driver Personnel.

Medical Transportation is provided only to access health services approved by Non-Insured Health Benefits (NIHB) – FNIHB Health Canada. Requests for Medical Transportation to access services that are not provincially insured or which do not fall under the parameters of (NIHB) will be denied except for Medical Transportation to Traditional Healers and Medical Transportation to Treatment Centers.

Client's Off-Reserve will need to contact FNIHB – 1-877-983-0911 regarding travel for their appointments if they are not eligible through the Medical Transportation Program On-Reserve.

MEDICAL TRANSPORTATION OVERVIEW
Assistance with Medical Transportation services are provided to members who live On-Reserve for medical travel and associated services for the following:

1. To the nearest appropriate facility;
2. The most economical and practical means of transportation considering clients condition;
3. The use of scheduled coordinated transportation;
4. Medical transportation in a non-emergency situation has been prior approved by Coordinator based on eligibility; and
5. Services not available in the home community.

DAILY ACTIVITIES

- Performing administrative duties and maintaining client files;
- Providing services to eligible Members living on reserve;
- Booking, verifying and rescheduling of appointments coordination;
- Recording and providing meal tickets for clients with Winnipeg appointments;
- Accommodations are provided with either private home or hotel, according to eligibility of client

(Surgery preps or post op care);

- Preparing OCA forms for private travel and appointment verification slips for clients;
- Recording all returned private travel forms;
- Preparing daily passenger logs for medical driver for Winnipeg log.

APPENDIX NIHB/MT-A NIHB Program Reports, Progress Activity Reports due Dates and Progress Activity Report Requirements.

Program Activity Report

1st	2nd	3rd Final
For Period Apr 1 to Aug 31	**For Period Sept 1 – Nov 30**	**For Period Dec 1 – Mar 31**
Due Oct 15	**Due Jan 15**	**Due June 30**
Fiscal Year: **2022 – 2023** **April 1 – August 31**	Recipient: **Pinaymootang First Nation**	**Contribution Agreement: MB0700072**
# of requests: **1094**	# of exceptions requested: **6**	# of appeals: **0**
# of requests approved: **979**	# of exceptions approved:	# of favorable appeals: **0**

How are the benefits being provided?

One full time/part time Medical Transportation Coordination is currently on hand to provide and assist clientele of appointments bookings, coordinating of transportation and acting as a supervisory capacity to the assistant and the medical drivers currently employed with the First Nation.

Currently employed are 3.5 full time drivers transporting clients to appointments. Each driver works on a rotating basis and are provided with a monthly schedule they are required to follow. On-call is often hired when needed.

We provide transport to nearest open facility available.

Major Accomplishments in the program during the reporting period:

Provided additional PPE to medical vans. The increase in services are slowly opening and vaccinations are being available to front line workers including those that are most vulnerable such as our dialysis clients.

The Medical Transportation private travel has increased.

The Medical Transportation program submitted for two new vehicles which were approved.

Major Challenges in delivering the program during this reporting period:

We have 8 dialysis clients of which are attending dialysis three times per week at the Lakeshore General Hos-

pital in Ashern, MB.

The increase in prenatal care, we provide travel at 38 weeks we also provide for high risk pregnancies.

The major challenges we are currently facing during this reporting period are letters from Physicians that are requested by clients to receive private travel. These letters are not honored. I have taken the initiative to contact these Physicians advising them of our policies and procedures regarding private transportation.

We have diagnosed cancer patients, that need to attend their treatment via private dravel due to compromised immune systems.

We still continue to face obstacles and challenges in our Medical Transportation Program. The increase in vehicle repairs, the utilization of 2 transport vehicles to transport dialysis to ensure social distancing and safety to our most vulnerable.

Increased and continue safety practices such as disinfecting and supplying and equipment vehicles with continued PPE such as face masks, gloves and sanitizers continues to be on-going.

Medical transportation is picking up discharge clients at various locations within the Interlake.

Transport coordination continues to be a huge challenge in this fiscal period. Medical Transportation has been on-call to provide services on a 24/7 -hour basis, due to many transfers, discharges, or emergency transport services.

Identify the factor (s) that may be impacting the budget:

Increase, in physician travel due to increase in much service from one to two days a week in order to prevent extended trips to Winnipeg, Ashern, Dauphin, Selkirk and Brandon.

The cost of fuel.

Repairs and Maintenance.

Other relevant observations, comments or information to this program:

The need for a FNIHB handbook is required to help clients understand the processes in policies and guidelines that the coordinator must follow. As the coordinator of the program, I find that having to say no to clients based on the criteria of private travel and other areas within the program, I feel that it would be beneficial to the program if there was a book to hand out as to how decisions are decided. The program does have this available on its website page, but not everyone utilizes this.

APPENDIX NIHB/MT-A NIHB Program Reports, Progress Activity Reports due Dates and Progress Activity Report Requirements

Program Activity Report

1st	2nd	3rd Final
For Period Apr 1 to Aug 31	**For Period Sept 1 – Nov 30**	**For Period Dec 1 – Mar 31**
Due Oct 15	**Due Jan 15**	**Due June 30**
Fiscal Year: **2022 – 2023** **Sept 1 – November 30**	Recipient: **Pinaymootang First Nation**	**Contribution Agreement: MB0700072**
# of requests: **757**	# of exceptions requested: **4**	# of appeals: **0**
# of requests approved: **757**	# of exceptions approved: **4**	# of favorable appeals: **0**

How are the benefits being provided?

One full time/part time Medical Transportation Coordination is currently on hand to provide and assist clientele of appointments bookings, coordinating of transportation and acting as a supervisory capacity to the assistant and the medical drivers currently employed with the First Nation.

Currently employed are 3.5 full time drivers transporting clients to appointments. Each driver works on a rotating basis and are provided with a monthly schedule they are required to follow. On-call is often hired when needed.

We provide transport to nearest open facility available

Major Accomplishments in the program during the reporting period:

Provided additional PPE to medical vans. The increase in services are slowly opening and vaccinations are being available to front line workers including those that are most vulnerable such as our dialysis clients.

The Medical Transportation private travel funding has increased.

Major Challenges in delivering the program during this reporting period:

We have 8 dialysis clients of which are attending dialysis three times per week at the Lakeshore General Hospital in Ashern, MB.

The increase in prenatal care, we provide travel at 38 weeks we also provide for high risk pregnancies.

The major challenges we are currently facing during this reporting period are letters from Physicians that are requested by clients to receive private travel. These letters are not honored. I have taken the initiative to contact these Physicians advising them of our policies and procedures regarding private transportation.

We have diagnosed cancer patients, that need to attend their treatment via private travel due to compro-

mised immune systems.

We still continue to face obstacles and challenges in our Medical Transportation Program. The increase in vehicle repairs, the Medical Transportation Vehicle transports 1 dialysis to Winnipeg, 3 times a week every Tuesday, Thursday, and Saturday until an opening becomes available.

Increased and continue safety practices such as disinfecting and supplying and equipment vehicles with continued PPE such as face masks, gloves and sanitizers continues to be on-going.

Medical transportation is picking up discharge clients at various locations within the Interlake.

Transport coordination continues to be a huge challenge in this fiscal period. Medical Transportation has been on-call to provide services on a 24/7 -hour basis, due to many transfers, discharges, or emergency transport services.

Identify the factor (s) that may be impacting the budget:

Increase, in physician travel due to increase in much service from one to two days a week in order to prevent extended trips to Winnipeg, Ashern, Dauphin, Selkirk, Brandon.

The cost of fuel.

Repairs and Maintenance.

Other relevant observations, comments or information to this program:

The need for an FNIHB book is required to help clients understand the policies and guidelines that the coordinator must follow. As the coordinator of the program, I find that having to say no to clients based on the criteria of private travel and other areas within the program, I feel that it would be beneficial to the program if there was a booklet to hand out as to how decisions are decided. The program does have this available on its website page, but not everyone utilizes this.

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Program Activity Report

1st	2nd	3rd Final
For Period Apr 1 to Aug 31	**For Period Sept 1 – Nov 30**	**For Period Dec 1 – Mar 31**
Due Oct 15	**Due Jan 15**	**Due June 30**
Fiscal Year: **2022 - 2023** **December 1 – March 31**	Recipient**: Pinaymootang First Nation**	**Contribution Agreement: MB0700072**
# of requests: **841**	# of exceptions requested: **8**	# of appeals: **0**
# of requests approved: **841**	# of exceptions approved: **8**	# of favorable appeals: **0**

How are the benefits being provided?

One full time Medical Transportation Coordinator is currently on hand to provide and assist clientele of appointment bookings, coordinating of medical transportation, and acting as a supervisory capacity to the assistant and the medical drivers currently employed with the First Nation.

Currently employed are 3.5 full time drivers transporting clients to appointments. Each driver works on a rotating basis and are provided with a monthly schedule they are required to follow.

We provide transport to the nearest open facility available.

Major Accomplishments in the program during the reporting period:

Provided additional PPE to medical vans. The increase in services are slowly opening and vaccinations are being available to front line workers including those that are most vulnerable such as our dialysis clients.

The Medical Transportation private travel has increase.

Major Challenges in delivering the program during this reporting period:

We have 6 dialysis clients of which are attending dialysis three times per week Monday, Wednesday and Friday. We have 3 dialysis clients attending three times per week on Tuesday, Thursday and Saturday at the Lakeshore General Hospital in Ashern, MB.

The increase in prenatal care, we provide travel at 38 weeks we also provide for high risk pregnancies.

The major challenges we are currently facing during this reporting period are letters from Physicians that are requested by clients to receive private travel. These letters are not honored. I have taken the initiative to contact these Physicians advising them of our policies and procedures regarding private transportation.

We have diagnosed cancer patients, that need to attend their treatment via private travel due to compromised immune systems.

Increased and continue safety practices such as disinfecting and supplying and equipment vehicles with continued PPE such as face masks, gloves and sanitizers continues to be on-going.

Medical transportation is picking up discharge clients at various locations within the Interlake.

Transport coordination continues to be a huge challenge in this fiscal period. Medical Transportation has been on-call to provide services on a 24/7 -hour basis, due to many transfers, discharges, or emergency transport services.

Identify the factor (s) that may be impacting the budget:

The increase in physician travel due to increase in much needed service from one to two days a week in order to prevent extended trips to Winnipeg, Ashern, Dauphin, Selkirk, Brandon.

The cost of fuel.

Repairs and Maintenance.

Other relevant observations, comments or information to this program:

The need for an NIHB booklet is required to help the clients understand the policies and guidelines that the coordinator must follow. As the coordinator of the program, I find that having to say no to clients based on the criteria of private travel and other areas within the program, I feel that it would be beneficial to the program if there was a booklet to hand out as to how decisions are decided. The program does have this available on its website page, but not everyone utilizes this.

Submitted by,

Maggie Anderson
Medical Transportation Coordinator

Home and Community Care Annual Report

This year has been full of hard work and accomplishments! Big shout out to our, Health Director and Health Centre Team for receiving Accreditation with Exemplary standing. This means that the Health Centre has met the highest level of performance, meeting the already high standards that Accreditation Canada sets.

Pinaymootang Home and Community Care staff have been working diligently to meet the growing needs of our clients. Our Team consists of 1 full time Nurse Supervisor, 1 LPN part time, and 3 full time Health Care Aides. Recently we welcomed Maegan, part time LPN and Lucille, full time HCA to our team.

PFN Health Home Care also offers Foot Care on a biweekly basis by Primary foot care nurse Brenda Henry. Upon completion of the Nursing Foot Care Course, I, Nancy am now also fully trained to assist with foot care when needed. Foot Care appointments can be made by calling reception at the Health Centre.

The Home and Community Care goal is to assist with maintaining optimal health and mental wellness in home and community. Serving clients living with chronic disease, acute illness, and supporting clients with disability. Assistance with preserving and maximizing the ability for community members to remain as safe and as independent as possible. Our program is not to replace, but to enhance the care already provided by family members. In the community we have 109 homes that have family members over the age of 60. We are currently assisting 150 (73 Male, 77 Female) active clients, 9 of which are on Dialysis. On average 67 clients per month receive direct service care.

In March of 2023, Ashern Dialysis opened 6 days a week increasing bed availability. This increase benefits our Dialysis clients, as they no longer have to travel to Winnipeg for care.

First Nations and Inuit Branch have introduced a new Data collection instrument system that has replaced eSDRT monthly uploading and reporting. Mustimuhw is our EMR charting system which is compatible with the new DCI program. Implementing the new Data collection instrument will improve statistics information and accuracy in reporting our hours of service provided.

The Home and Community Care Program consists of the services listed below.

Nursing Services:

- Nursing Process; assessment, diagnosis, planning, implementation, evaluation of care.
- Vital Signs including blood pressure, pulse, temperatures, blood sugars and oxygen levels.
- Phlebotomy services, and monitoring results
- Medication administration and monitoring
- Wound Care/Foot Care

- Physical Assessment, ordering, assembly, and delivery of safety equipment.
- Providing various health education.
- Communication and referrals to appropriate Healthcare providers and Specialists.
- Client Care plans and Medication reviews
- Patient advocating/Hospital Rounds Tuesday's weekly
- Assistance with the Long-Term Care panel process
- Homemaking (PFN Social Program) referrals

Personal Care:
- Health Care Aides/Nurse provide supports assisting with activities of daily living.
- Monitoring vital signs, reporting abnormal readings to Nurse supervisor

Medical Supplies and Equipment:
- Assessment of client specific needs and ordering equipment to provide a safe home environment, as well as safe client mobility.
- OT/PT outpatient referrals

Home Management/Homemaking Services:
- This is a PFN Social Services program. Assessments are completed by the Nurse at request of the client and submitted to the social program at the Band Office for further consideration and approval.

In Home Respite:
- Depending on available staff resources, Health Care Aides may be scheduled for a specific time, or at periodic intervals to stay with a client during the time that a caregiver may be away. A request must be submitted in advance to ensure the adequate staff resources are available.

Palliative Care:
- Programing is funded by Health Canada.
- Designed to allow a client to have the resources and supports needed for end-of-life care in the comfort of their own home.
- Nurse and Certified Health Care Aides along with a family support system, provide the family with assistance caring for their loved ones at home.

Statistics:
- Home visits: 336
- Health Centre visits: 179
- Hospital Visits: 19
- Wound care management: 212 (included in visit count)
- Medication management: 71 (included in visit count)
- Information entries, telephone conversations and wellness checks, programs, Liaison and Linkages, Doctor and specialist referrals and consults: 995
- Foot Care: 18 (included in visit count)
- Nurse Supervisor total encounters (April 2022-March 31, 2023): 1529
- Health Care Aides total encounters/LPN/Foot Care (April 2022-March 31, 2023): 3217
- Home and Community Care total encounters all staff (Fiscal year 2022/2023): 4746

Encounters noted above are not including homecare clients/Other clients seen through the clinic by Health Centre Nursing.

Description of Training/Conferences in the 2022/2023 Fiscal Year:

- Completion of Nursing Foot Care Distance Education Program
- FNHSSM Long Term Care Strategy Planning meeting
- Harm Reduction Training (HCAs) Nursing staff unable to attend due to staffing shortages.
- ASSIST training (HCAs) Nursing staff unable to attend due to staffing shortages.
- Accreditation Canada Process

Professional Development Workshop

- Tribal Council Home and Community Care and Independents Quarterly meetings
- Meetings with University of Manitoba and Heart and Stroke Foundation. Working in collaboration to bring Physiotherapy services to community.
- Health Director Proposal for Adults with Exceptionalities meeting.
- QDoc meeting to discuss virtual doctor services available to client's if unable to see a local doctor.
- Data Collection Instrument Training
- Mustimuhw upgrades and Training
- Restoring Resilience from Isolated to Integrated

Along with my role as the Home and Community Care Nurse Supervisor and direct service nurse, I also assist in clinic, assist with vaccine clinics, and work closely with other programs within the Health Centre.

Our Health Care team works in collaboration to ensure that each client receives the advocacy and treatment that is specific to their needs. It is truly an honor to work in such a beautiful community.

Nancy Friesen

Home and Community Care Health Care Aide Annual Report

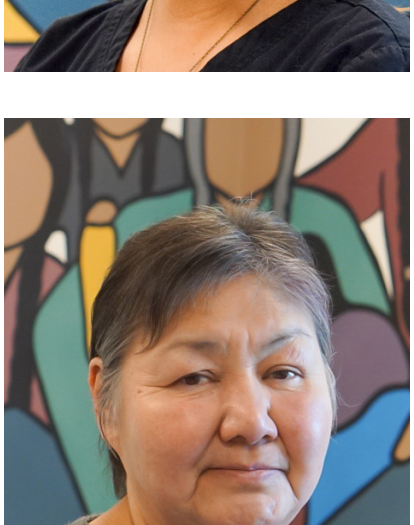
Greetings, from the Home and Community Care Program. Dorothy Sumner has been employed at the Health Centre since (2012), Jody Sinclair (2019) and Lucille Ross is our newest member since January (2023) (Not shown in report).

Health Care Aides work under the guidance and supervision of the Home and Community Care Coordinator.

It is a privilege to care for our elders, persons living with acute/chronic conditions and persons with exceptionalities. We will remain diligent in providing attentive care for our clients in the H.C.C Program.

The Home and Community Care Objectives are:

- To provide community care and support to a range of people: including elders and community members with short term or long-term medical conditions and persons with exceptionalities.
- To provide care for clients who need assistance in the home after hospital discharge.
- To enable clients to remain in their own homes as healthy and as independent for as long as possible to delay and prevent admission to a health facility.
- To promote dignity, independence, preferences, privacy and safety at all times when in the client's home.



Supportive Care:

- Support is provided to various clients according to client's care plan.
- In home assistance is provided for clients after hospital discharge.
- Assist clients with activities of daily living such as bathing, grooming and dressing.
- Refer clients to the foot care nurse.
- Assist with range of motion exercises.
- Home visits are done to monitor client's vital signs which are blood pressures, blood sugars, oxygen levels, respiration and temperatures.
- We provide mobility aides including mechanical beds, safety bed rails, grab bars, commodes, bathing equipment, wheelchairs, canes, walkers and reach extenders to meet client's needs. We also provide incontinence products
- Medication delivery is provided for clients in the program.
- One staff member is fluent in the Ojibwe language.

Recording and Reporting:

- Each home visit is documented.
- Any concerns are reported to the Home Care supervisor.
- Initiate client referrals to the Home Care supervisor or refer client to appropriate program area.

Activities:

Nutrition hampers were given to elders. Community clean up, Vaccination Clinics, Annual Health Fair, Health Fair Breakfast.

Workshops/Training:

- IPAC Hand Hygiene,
- Paramedic Providing Palliative Care at Home,
- Accreditation Education Workshop,
- BLS Training,
- PFN Health Policies & Procedures by Zoom,
- Health Fair,
- Home & Community Care Training,
- Harm Reduction Training,
- Assist Training,
- Staff Professional Development Workshop – Restoring to Resilience; from Isolated to Integrated.

Statistics:

	Home visits/HC visits	Baths	Med deliveries/ Equipment	Total Encounters
Dorothy	179	147	769	1095
Jody	407	148	1128	1683
Lucille	19	10	74	103

Aboriginal Head Start Outreach Program Annual Report

Hello everyone! My name is Cherish Sumner. I am the Aboriginal Head Start On-Reserve Home Visitor Coordinator with Pinaymootang Health. My journey began in September of 2017 as the front desk receptionist. I transitioned on to working as the AHSOR Coordinator. As of August 2023, I am a fully certified Early Childhood Educator Level II – after completing full-time studies and receiving my diploma from Robertson College.

The AHSOR program focuses on six main components: Culture and Language, Education and School Readiness, Health Promotion, Nutrition, Social Support, and Parental and Family Involvement. Each component is directed by allowing them to experience each area through home visits, playgroups, day trips, or through the online learning experiences with the Aboriginal Head Start On-Reserve social media posts - as a curriculum-based learning experience with their families (posts that are interactive through the social media page that was created in March of 2021 due to the Covid-19 pandemic).

The AHSOR program strives on having children reach their full potential in life. From the age range of 0-5, this is the time frame of when a child learns the most during their early years. Their brains are still growing after birth and they are making the most neural connections than at any other age in their lifetime. These neural connections are what build the areas of cognitive development, language development, social/emotional development, and physical development. By ensuring that we are helping children be school ready through home visits and group programming, this is what drives me to do what I love to do.

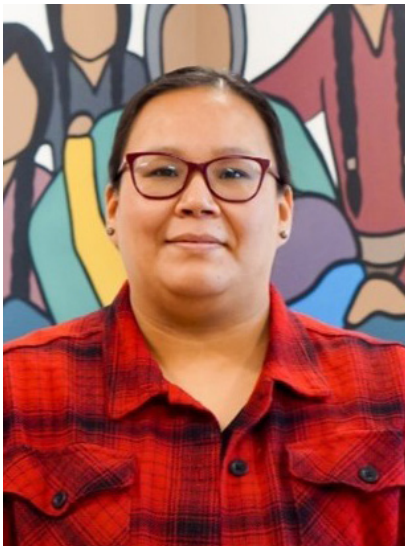
Home visits consist of the Aboriginal Head Start On-Reserve outreach worker to visit the children and parents in the comfort of their home, and conduct a survey called the "Ages and Stages Questionnaire", which is to be completed by both the parent/caregiver and myself by interacting and engaging with the child – through interacting with the children during the survey. The Ages and Stages Questionnaire's have a charting system that allows us to see where the children are within the 5 domains of child development and what resources can be offered if needed. Aside from home visits, we engage in playgroups and family programming that includes things such as day trips, playgroups, cooking, and parental information sessions.

The AHSOR program is associated with the Dolly Parton Imagination Library. This is a free book program that mails books to children from birth until their 5th birthday. To date we have 119 children who receive books in the mail from the Dollywood Foundation every month.

It has been an exciting journey to be able to work with such amazing families and wonderful children within our community and I look forward to what the future has in store for our future generations. Thank you for allowing me to be a part of it.

Ages and Stages Questionnaire's	337	Referrals	11	Encounters	389

Cherish Sumner



My Child, My Heart Program Annual Report

Tansi, my name is Amber Bruce, and I am the Assistant Case Manager for the Niniijaanis Nide (My Child, My Heart) Program with the Jordan's Principle Child First Initiative. I have been with this program since March 2021. My job titles have changed a few times over the last two and half years. As I started off as a Child Development worker, then moved to an Administrative Assistant/School Coordinator, which then led to my role now as Assistant Case Manager.

I am not originally from here, I married over 15 years ago into the community and since been here on and off. It was not until four years ago that we decided to come home and make Pinaymootang our forever home. My husband Jeremy and I have two boys, which happen to have an age gap of 10 years. I am currently finishing off my third year, working towards my dual Bachelor of Education/Bachelor of Arts degree being offered here through the learning Hub with the University of Manitoba. My dream has always been to work with and for our children, as they have a big place within my heart. My job experiences have always been in such roles involving children. I am extremely grateful for this opportunity to work within my family's community.

Our Jordan's Principle program was established within our community in December of 2015. When focusing on the health and wellness of our children, families and community, we will strive to provide holistic teachings and knowledge to our children's life. Our goal within our program is to ensure the involvement of our community to build healthy ways of life for our children. The purpose of our Jordan's Principle program is to have a child first initiative that aims too eliminate service inequalities and delays for our First Nation's Children. Jordan's Principle states that any public service ordinarily available to all other children must be made available to First Nations children without any delay or denial. Currently we have 191 children within our Pinaymootang Jordan's Principle Program.

The Child Development Workers work with the Case Managers, Parents, Teachers, School Coordinator, and the visiting Professionals to help identify the children's Strengths and needs; together we find ways to assist the child and family with established goals to improve their lives. They are involved in assisting with the child's overall wellbeing whether it be in the home, community, or the school setting. Children who attend school are seen on a weekly basis in the classroom setting. Weekly home visits for children who are not attending school are strongly encouraged to ensure that families are receiving the level of support/services that they are entitled to. The Child Development Workers also assist the Land Based Coordinator and Recreation Worker in programming throughout the summer.

Transition Wellness Worker's role is to work with the youth in the program who are at various stages of transitions to adulthood. They also assist families in supporting their children to transition smoothly to adulthood. All programming has a specific focus aimed at skill building, improving self-worth/self-esteem and confidence thus ensuring our youth enter their adult phase of life feeling empowered and ready to achieve all their goals.

The ASL Educator who is also our Transition Wellness Worker works closely with the families who require ASL services

and education. We provide one on one classes in the home, school, or virtual setting. We coordinate educational opportunities for children and their families to further their ASL skills but taking the ASL courses to get certified. Home visits are encouraged to make learning ASL enjoyable and simple as possible. We always incorporate fun into our learning by utilizing story telling such as books or puppets.

Our Land Based Educators delivers land-based activities/programming to our children/youth and families that support reconciliation and promote a sense of community that will improve mental, physical and spiritual wellness. Land based activities empower people by developing a connection to the land and giving tools to protect and fight for it. Our Land Based Educator develops and delivers land-based learning opportunities for our children, youth and community with the seasons guiding the program content.

Our In-School Coordinator plays an important role in ensuring that communication is clear and consistent within the school setting and between all service providers in our children's circle of care. This job entails coordinating the Child Development Worker's schedules. Working alongside the school resource team and assisting in fulfilling and identifying any gaps that need to be met as per the Jordan's Principle initiative. Our School Coordinator also ensures that the child's wholistic needs are being met by paying attention to the children's physical, personal, social, emotional and spiritual wellbeing, as well as cognitive aspect of learning. The School Coordinator tries to ensure that all services are being met and delivered in a well-coordinated, consistent and timely manner.

Jordan's Principle Administrative Assistant role involves the coordination of all office activities that include not limited to weekly programming, financial support, coordination of meetings, minute taking, and all other administrative duties assigned.

Our Intake Coordinators play such a significant role in client intakes. They have gone that extra mile and are responsible for intake, initiation and maintenance of client information for the provision of effective and efficient communication and service supports targeted to children currently enrolled in the Jordan's Principle Child First Initiative Program.

Our Rehabilitation Assistant role involves the coordination of all the 0–4-year-old children within our program to assist with appointments with our visiting professionals. They make sure that there is clear and consistent communication between all parties. They also assist in any other area that is needed within our program. The rehabilitation assistant also runs programs such as fine motor groups, speech groups, as well as self-regulation groups.

We at the Jordan's Principle program very much values the Anishinaabe language. The language gives out children knowledge about their Culture and it develops a sense of belonging. Throughout the year we had Elders share their wisdom, teachings, and stories. This not only supported our children but helped them to grow strong and proud in who they are. We see our Elder's as an integral role in the delivery of our Language to our children, youth, and community. We envision this service being offered in the Nursery and Daycare setting as well. Our ultimate goal is to incorporate the benefits of our Language into all aspects of our Jordan's Principle programming.

We work collaboratively with Mental Health Services here within our Health Centre as well as having access to other similar services outside the community. Our Children/Youth's Mental Health is very important as their Physical Health. The community continues to have access to personal therapy which is available by appointment every day of the week from Monday-Friday.

Programming undertaken this fiscal year:

Monthly visits from RCC, St. Amant Social worker, Dietitian, mom and tots group, walking club, fine point motor skills group, speech and language group, homework club, American Sign Language club, land based activities; trapping, deer skinning, ice fishing, Mother's Day brunch, Father's Day horseshoe tournament/BBQ, outdoor recreation activities, orange shirt day-every child matters, pink shirt day-anti-bullying day, winterfest: community breakfast, week long activities for the community, fishing derby, easter gift baskets, Winnipeg Goldeyes game, Red River Ex, Strawberry

picking, Wellness camp gatherings, Parent/guardians planning meetings and meet and greet, various virtual events for families, Family training at St. Amant, Manitoba School of the Deaf training, community clean up, land based harvesting teaching, winter clothing drive, Christmas party along with incentive, santa claus parade, Wasagaming camping, kayaking, sports days, milestone & development groups, back to school supply giveaway, self-regulation group, kids & teen grief group, music class, cooking class, March day camps.

Programming stats for some of the programs in 2022-2023 year:

Rehabilitation Centre for Children
Counselling Services
Recreational Activities
Parent Gathering
Family Sessions
Milestone Development groups
Land Based Programming
Seasonal Programming
Reading Clubs
Safety Activities
Physical Activities
Mental Health Activities
Spiritual Components

Throughout this Fiscal year there was 2495 clients in our various groups.

We as a program are committed to delivering comprehensive, consistent and community-culturally based resources/programming/services to the families of this community. We are excited that we will be working on increasing our programming to better serve the needs of all the children and families in the Jordan's Principle program. We as a program are committed to ensuring that we make the time to meet all our families within the program to ensure that our individual needs are being addressed in an appropriate and timely manner.

Thank you and looking forward to another new year.

Amber Bruce – Assistant Case Manager

Drinking Water Safety Program Annual Report

The Drinking Water Safety Program falls under the jurisdiction of FNIHB. The Health Program receives funding for a part time Community Based Water Monitor (CBWM). The purpose of this program is to ensure safe drinking water and proper services are provided to the Community.

The Drinking Water Safety Program is important in exposing potential risks that may be present in drinking water supplies and are identified through testing of public wells and private well supplies. With the guidance of the Kiran Sidhu, Environmental Health Officer from First Nations Inuit Health Branch (FNIHB) has set up a sampling plan that is unique to the community and its environmental situations.

The Pinaymootang First Nation, Drinking Water Safety Program conducts the following:

- Sampling frequencies twice a year for private wells;
- Conducts weekly testing to public building wells and distribution systems;
- Chlorine residual testing is done at four (4) locations once a week in the community; two (2) at the school distribution system and two (2) at the town site pump houses.
- Community awareness by way of newsletter information;
- Boil water advisories;
- Well Chlorination;
- Provide Food Safety Course (Food Handlers) to community

Microbiological testing on water samples collected is tested for Total Coli Forms and Escherichia Coli (E-Coli) and is done within the Health Centre. The test detects bacteria in the water sample by using a Coli-sure agent which is provided by FNIHB. The testing process takes 24-28 hours in an incubator with a set temperature at 35 Celsius. After a minimum of 24 hours in the incubator, samples are taken out and results are documented.

Please note: water samples are lower this year due to transfer of old waters system to the new system.

Evan Anderson

COLILERT (QUANTI-TRAY) AND ETL MONTHLY RESULTS
April 2022 – March 2023

MONTH	WTP/DS-S	WTP/DS-US	WELLS-	WELLS-US	TOTAL-S	TOTAL-US
April	17	0	0	0	17	0
May	16	0	0	0	16	0
June	10	0	0	0	10	0
July	31	0	0	0	31	0
August	10	0	0	0	10	0
September	09	0	0	0	09	0
October	07	0	0	0	07	0
November	46	0	0	0	46	0
December	19	0	0	0	19	0
January	16	0	0	0	16	0
February	26	0	0	0	26	0
March	31	0	0	0	31	0
TOTALS	**238**	**0**	**0**	**0**	**238**	**0**

WTP: WATER TREATMENT PLANT DS: DISTRIBUTION SYSTEM WELLS: PRIVATE WELLS

S: SATISFACTORY BACTI RESULT (TOTAL COLIFORM: <1 / FECAL COLIFORM: 0)

US: UNSATISFACTORY BACTI RESULT (TOTAL COLIFORM: >1 / FECAL COLIFORM: 1 OR MORE

Health Transformation Liaison (SCO) Annual Report

Hello, I am the Community Health Transformation Liaison (CHTL) for Southern Chiefs' Organization (SCO) at Pinaymootang Health Centre. Health Transformation is focused on improving the First Nation health system by involving First Nations in decision-making processes.

Through community-driven engagement, SCO works with First Nation partners and governments to build a Southern First Nation health system in Manitoba. This system aims to provide culturally responsive healthcare services, closer to the community. We also aim to strengthen partnerships with the provincial health system for better healthcare, including culturally safe practices.

As Community Health Transformation Liaisons, we organize sessions and events, gather community feedback, and provide support and resources for community involvement. Our mission is to work together with the community to bring positive changes to First Nation healthcare, ensuring that our people's needs and voices are prioritized.

In November I started collaborating with NADAP to implement land-based programming for Pinaymootang. We started by hosting an Elder's meeting to discuss the opportunities that our community elders would like to see. Following that, we arranged activities including a deer harvest where participants were able to bring home deer meat, as well as workshops on healthy relationships where we saw significant interest. Additionally, I took part in an addiction's awareness workshop featuring special guests NHL alumni Jason Simon and the Ivan Flett Memorial Dancers.

In closing, this has been a great year for our health center as we achieved the highest level of accreditation from Accreditation Canada. Our goal in doing so is to provide better healthcare for our community, promoting improved health and well-being.

Health Transformation promotional meetings and gatherings:

- Winona LaDuke Presentation on May 10, 2022 (Zoom)
- SCO Community Health Walk on August 10, 2022
- Let's Talk Treaty with Harry Bone (zoom) on October 21, November 18, December 16, 2022
- Cultural/Traditional & Community Events Participation:
- Medicine Picking Day Trip – April 9, 2022
- Pinaymootang Community Days – June 4, 2022
- Community Clean Up BBQ – June 15-16, 2022
- Pinaymootang Treaty Days Pancake Breakfast – August 17, 2022
- Pinaymootang Health Fair – August 18, 2022
- Treaty Days – August 16-20, 2022

- Medicine Picking with Men's Group – October 11, 2022
- Deer Harvest in Pinaymootang – January 17, 2023
- Healthy Relationships Workshop – January 19, 2023
- Engagement/Activities:
- Virtual Easter Basket Draws – April 11-14, 2022
- In-Person Food Safe course – April 26, 2022
- Moccasin/Wrap Around Classes June 7, 14, 20, 2022
- Food Handler's Training – July 19, 2022
- Grandmothers & Mother's Gathering collab with MCH July 7, 2022 at Wellness Camp
- "Make a Planter" workshop with Dementia Program July 28, 2022
- Zoo Day Trip with children ages 0-6 and families (with AHSOR & MCH) – August 15, 2022
- Men's Wellness Group – bi-weekly from August 2 to November 29, 2022
- Prairie Dog train ride with Elder's – September 25, 2022
- Truth & Reconciliation Day Gathering – September 2022
- Grandparents Day Celebration with AHSOR @ Wellness Camp – September 9, 2022
- Prenatal Class Workshop with MCH October 24, 2022
- Cooking with Kids Workshop on October 26, 2022
- Elder's Halloween Party on October 27, 2022
- Prenatal Workshops/Infant Moccasin Classes Nov 7, 14, 22, 24 with MCH and ACFS
- Fish Fillet Cooking Class November 17, 2022
- Pinaymootang Health Centre Community Christmas Party – December 8, 2022
- Bell Let's Talk Day Men's Group & Women's Group January 24-25, 2022.

Meetings with Community	20
Engagements/Activities	48
SCO Meeting requirements	40
Training/Workshops	13

Christina Sutherland

Dementia Project (University of Manitoba) Annual Report

The intent of this project is to help people living with Dementia and their caregivers to lead a happy and fulfilling life; to mitigate risk factors in the community that impact dementia; and to mobilize the knowledge we have by developing training materials that can be share with other indigenous communities who may wish to learn from our experiences.

I have thoroughly enjoyed this past year, being able to create new relationships with community members as well as strengthening previous ones, supporting those LWD and their loved ones, and being able to see this program thrive to be an example for other communities who may wish to follow. We have had a successfully busy past year!

Engagement:

- Support from Home and Community Care with families.
- Engagement from Maternal Child Health Program and Southern Chief's Organization to incorporate Elder's into additional programming to encourage them to share cherished memories and teachings with one another.
- Contact with Alzheimer's Society for resources to provide to families.
- Held Alzheimer's Society presentation with facilitator to provide the community with a different opportunity to learn.
- Presenter in the CDLRN Annual Forum outlining our program with other community facilitators.
- Participation in Paramedics providing Palliative Care at Home presentation to bring to community.

Output:

- Educational folders specific to the person's requests.
- General Dementia Information
- Caregiver supports, tips and coping.
- Diagnosis process & next steps.
- Educational posters for Facebook & throughout the Pinaymootang Health Centre.
- Recognizing signs with your loved one.
- Sensory changes in Dementia.
- Alzheimer's Presentation.
- Grandmother's and mother's Gathering.
- Benefits of Diagnosing Dementia
- Social Connection – Made with Elders who participate in program.

Total Home/Social Visits: 253

- Detailed reports made after each visit, including first introductions.
- Follow ups with families that received information upon request.
- Direct support to families in search of extra supports.
- Support from Health Care Aides during initial introductions.

Research/Education:

- Toolkit created by OT & PT Students, continued by Community Liaison as a resource.
- Responsive behaviors toolkit from the Australian Alzheimer's Society.
- Restoring Resilience: from Isolated to Integrated
- CPR & First Aid
- Building Dementia Friendly Communities – Inclusivity to those LWD.
- Finding your way – Living safely in the community.
- Nutrition & Dementia.
- Loss & Grief in Dementia.
- Caregiver stress and building resilience.
- Enhancing Family Dynamics.

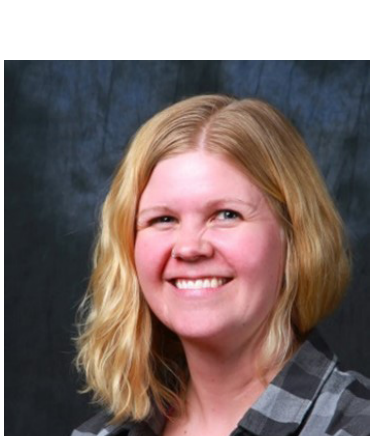
Next steps:

- Continued home & social supports.
- Increased educational supports for families.
- Working together with the Alzheimer's Society to continue to provide the best support for our community members.
- Continued education to provide the most up to date educational supports for families.

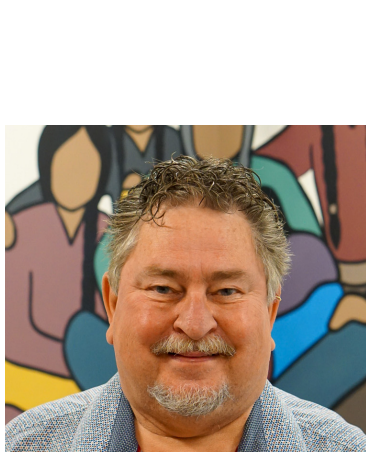
A grant was also received for Elder programming. The grant supports a program for a one-year term, a program was developed and named the "Community Elder Support Program" which directly supports all elders in the community to provide activities that will target social interaction, physical activity & improvements in mental health.

Emily Thorlacius

Pinaymootang First Nation Health Professional Services



Jahna Hardy is the visiting Mental Health Therapist, Jahna provides counselling services in the community two days per week (every Monday and Tuesday) referrals and appointments can be made through the Health Centre for anyone wishing to utilize.



Randal Klaprat is the visiting Mental Health Therapist; Randal provides counselling services in the community three days per week (every Wednesday, Thursday and Friday) referrals and appointments can be made through the Health Centre for anyone wishing to utilize.

Lucy Diaz who originates from Nova Scotia, Lucy is our Dental Therapist; Lucy provides services to the community every Tuesdays for dental care services for school aged children and will book adult emergency by appointment only.

Phyllis Wood is a community member of Pinaymootang, Phyllis provides administrative supports to the Dental Therapist.

Pinaymootang First Nation Health Program

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